

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2014
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF HAYSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 215 N LAMAR AVE HAYSVILLE, KS 67060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 309 SS=E	<p>The following citations represent the findings of complaint investigation #71437</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: The facility had a census of 95 residents. The facility identified 18 of the 95 residents took pain medications on an "as needed" basis. The sample included 3 residents that received PRN (as needed) pain medications. Based on observation, interview and record review the facility failed to follow the physician's order for administration of "as needed" Percocet for one sampled resident (#3) and failed to identify the location of the resident's pain for 3 of 3 sampled residents who requested pain relieving medications. This had the potential to affect all 18 residents that had orders for "as needed" pain medications.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Review of the E-MAR for resident #3, dated 11-13-13 identified the staff administered Percocet 5-325 milligrams to the resident at 1:21 AM and again at 11:51 AM. The physician's 	F 309			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2014
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF HAYSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 215 N LAMAR AVE HAYSVILLE, KS 67060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 1</p> <p>order dated 11-12-13 directed, give Percocet 5-325 mg(milligrams) every day PRN (as needed) for pain.</p> <p>Interview with licensed nurse B on 1-13-14 at 3:14 p.m. revealed the nurse gave a second dose of Percocet within the same day. The nurse stated at report time when he/she came on duty the off going nurse should have given report that he/she gave the resident Percocet during his/her shift. When asked if the nurse checked narcotic logs and EMAR's prior to giving a PRN medication, he/she said yes, but offered no reason for administering the second dose of Percocet on the 13th.</p> <p>On 1-13-14 at 3:30 PM administrative Staff Nurse A said he/she understood the problem related to administering the PRN medication twice on 1-13-14.</p> <p>The facility administered Percocet twice during the 13th, rather than once as ordered.</p> <p>- Review the the E-MAR dated 11-13-13, for resident #3 identified the resident received Percocet for pain with an intensity of 10 (on a scale of 1-10 with 10 being the most intense pain) at 1:21 AM and 11:51 AM on 11-13-13. The E-MAR did not have any location of the pain noted for either time.</p> <p>Interview with Licensed Nurse B on 1-13-14 at 3:14 p.m. revealed the E-MAR (record for electronically documenting administration of medications) did not have an area to document the location of pain when a nurse administered a pain medication. The only area for documentation was the intensity of the pain on a</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2014
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF HAYSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 215 N LAMAR AVE HAYSVILLE, KS 67060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 2 scale of 1-10.</p> <p>Interview with Administrative Nurse A on 1-13-14 at 3:30 p.m. revealed he/she expected the nurses to chart the location of pain in the nursing notes when giving a PRN pain medication. He/she said there was no location on the E-MAR to chart that information, only the intensity of the pain. Nurse A reviewed the nursing notes related to the dates staff gave the resident the PRN pain medications and found no documentation of the location of pain for the PRN pain medications administered.</p> <p>On 1-13-14 at 4:45 p.m. Administrative Nurse A said he/she called about inclusion of the location of pain on the EMARS for PRN medications given in the future. He/she said as soon as he/she received the code, a change in the requirements of documentation would change on the electronic charting system. He/she said the nurses should document the location so they know if the pain is in the same area always, and also know if depending on the location of the pain there might be other non-pharmacological interventions that might work or if the resident developed a new site of pain.</p> <p>On 1-13-14 at 4:45 p.m. Administrative Nursing Staff A said there was no policy related to what criteria the nurses should include when administering PRN pain medication.</p> <p>The facility failed to ensure the documentation of the pain assessment, including location of the pain to enhance further assessments of pain.</p> <p>- Review of the E-MAR for resident #2 dated January 2014 included administration of PRN (as</p>	F 309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2014
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF HAYSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 215 N LAMAR AVE HAYSVILLE, KS 67060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 3</p> <p>need) Lortab 10-500 mg (milligram) tablet on 1-12-14, at 12:35 PM; and 1-14-14 at 9:04 AM for pain. EMAR notes for each only included the intensity of the pain, and not the location.</p> <p>Interview with Licensed Nurse B on 1-13-14 at 3:14 p.m. revealed the E-MAR (record for electronically documenting administration of medications) did not have an area to document the location of pain when a nurse administered a pain medication. The only area for documentation was the intensity of the pain on a scale of 1-10.</p> <p>Interview with Administrative Nurse A on 1-13-14 at 3:30 p.m. revealed he/she expected the nurses to chart the location of pain in the nursing notes when giving a PRN pain medication. He/she said there was no location on the E-MAR to chart that information, only the intensity of the pain.</p> <p>On 1-13-14 at 4:45 p.m. Administrative Nurse A said he/she called about inclusion of the location of pain on the EMARS for PRN medications given in the future. He/she said as soon as he/she received the code, a change in the requirements of documentation would change on the electronic charting system. He/she said the nurses should document the location so they know if the pain is in the same area always, and also know if depending on the location of the pain there might be other non-pharmacological interventions that might work or if the resident developed a new site of pain.</p> <p>The facility failed to ensure the documentation of the pain assessment, including location of the pain to enhance further assessments of pain.</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2014
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF HAYSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 215 N LAMAR AVE HAYSVILLE, KS 67060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 4 - Review of the E-MAR for resident #1 dated January 2014 included administration of PRN (as need) Tylenol on 1-1-14, at 2:53 AM for pain. The EMAR notes only included the intensity of the pain, and not the location. Interview with Licensed Nurse B on 1-13-14 at 3:14 p.m. revealed the E-MAR (record for electronically documenting administration of medications) did not have an area to document the location of pain when a nurse administered a pain medication. The only area for documentation was the intensity of the pain on a scale of 1-10. Interview with Administrative Nurse A on 1-13-14 at 3:30 p.m. revealed he/she expected the nurses to chart the location of pain in the nursing notes when giving a PRN pain medication. He/she said there was no location on the E-MAR to chart that information, only the intensity of the pain. On 1-13-14 at 4:45 p.m. Administrative Nurse A said he/she called about inclusion of the location of pain on the EMARS for PRN medications given in the future. He/she said as soon as he/she received the code, a change in the requirements of documentation would change on the electronic charting system.. He/she said the nurses should document the location so they know if the pain is in the same area always, and also know if depending on the location of the pain there might be other non-pharmacological interventions that might work or if the resident developed a new site of pain.	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/27/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175133	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/15/2014
NAME OF PROVIDER OR SUPPLIER DIVERSICARE OF HAYSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 215 N LAMAR AVE HAYSVILLE, KS 67060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 5 The facility failed to ensure the documentation of the pain assessment, including location of the pain to enhance further assessments of pain. This failure had the potential to effect all 18 residents with PRN pain medications ordered.	F 309			